Disclosure of Ownership, Business Transactions & Exclusions Statement for Providers

I. Instructions

This statement should be completed and submitted to each of the health plans listed on page 4. This statement must be submitted by the deadline set by each of the health plans and upon contract renewal. A new statement must be submitted when any information in your statement has changed.

You should complete this form in conjunction with review of the requirements for disclosure of ownership, business transactions and exclusions of individuals and entities from government programs as provided in each of the health plan's administrative requirements.

This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information.

For assistance in completing this statement, please reference the "Definitions" on page 5.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS			DBA
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER ( )
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ **Sole Proprietorship** ☐ **Partnership** ☐ **Corporation** ☐ **Limited Liability Co.** ☐ **Non-Profit**

☐ **Other Partnership (i.e., LP, LLP, LLLP)**

IV. Ownership & Control Interests

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	% of Ownership Interest	SSN or FEIN	Drivers License No.	Relationship
1						
2						
3						

This form has been approved for use by the following members of the Minnesota Council of Health Plans: Blue Plus, First Plan, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare

B. If any Person with an Ownership or Control Interest listed in subsection IV(A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	% of Ownership Interest	SSN or FEIN	Drivers License No.	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Name of Individual, Business or Organization	Name of Other Organization	Address	SSN or FEIN	% of Ownership Interest
2					
3					

V. Significant Business Transactions

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars ($25,000) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists, please indicate this with an "N/A."

No.	Name of Subcontractor	Address	SSN or FEIN	% of Ownership Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

No.	Name of Wholly-Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

This form has been approved for use by the following members of the Minnesota Council of Health Plans: Blue Plus, First Plan, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare

VI. Excluded Individuals or Entities

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees, Agents or Subcontractors who have ever:

- Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?

  ☐ Yes ☐ No

- Been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

  ☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

No.	Name	SSN or FEIN	Reason
1			
2			
3			

VII. Certification

I certify that the above information is true and correct. I will notify each of the health plans listed below of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	**DATE**
EMAIL ADDRESS	

This form has been approved for use by the following members of the Minnesota Council of Health Plans: Blue Plus, First Plan, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare

Return a completed, signed statement to each of the following:

Blue Plus

- Fax to: 651-662-7362
- Mail to:
  Blue Cross and Blue Shield of Minnesota
  P. O. Box 64560
  Route R337-BR
  St. Paul, MN 55164-0560
- Questions: 651-662-5200 or 1-800-262-0820

First Plan

- Email to: Communications@First-Solutions.org;
- Fax to: 218-727-7247
- Mail to:
  525 South Lake Avenue, Suite 222
  Duluth, MN 55802
- Questions: 218-740-2325

HealthPartners

- Email to: beverly.g.vacinek@healthpartners.com
- Fax to: 952-853-8708
- Mail to:
  8170 33rd Avenue South
  Mail Stop 21108C
  Bloomington, MN 55425
- Questions: 952-883-5649

Medica Health Plans

- Email to: DisclosureStatement@medica.com;
- Fax to: 952-992-8350
- Mail to:
  Medica
  Mail Route CW210
  P.O. Box 9310
  Minneapolis, MN 55440-9310
- Questions: 1-800-458-5512

Metropolitan Health Plan

- Mail to:
  MHP
  400 South Fourth Street
  Suite 210
  Minneapolis, MN 55415
  Attn: Front Desk.
- Questions: 1-877-620-9090

UCare

- Email to: PNM_FAX@UCare.org
- Fax to: 612-884-2232
- Mail to:
  UCare
  P.O. Box 52
  Minneapolis, MN 55440-0052
- Questions: 612-676-3300

This form has been approved for use by the following members of the Minnesota Council of Health Plans: Blue Plus, First Plan, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare

For the purposes of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

2. **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the Provider.

3. **Ownership Interest** means the possession of equity in the capital, the stock, or the profits of the Provider.

4. **Person with an Ownership or Control Interest** means a person or corporation that: A) has an Ownership Interest, directly or indirectly, totaling five percent (5%) or more in the Provider; B) has a combination of direct and indirect Ownership Interests equal to five percent (5%) or more in the Provider; C) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least five percent (5%) of the value of the property or assets of the Provider; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).

5. **Provider** means an individual or entity that has entered into an agreement with any of the health plans listed on page 4 of this statement and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

6. **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of the Provider's total operating expenses.

7. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted or delegated some of its management functions or responsibilities of providing medical care to patients.

8. **Wholly Owned Supplier** means a supplier (i.e., an individual, agency, or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.